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ABSTRACT

At the request of Congressman William Green, the General Accounting Office (GAO) evaluated the validity of allegations about deficiencies in the New York State Department of Health's nursing home and hospital inspection processes for certification for participation in the Medicare and Medicaid programs. Health Care Financing Administration and state policies, procedures, and practices for investigating complaints, performing inspections, and determining nursing home and hospital compliance with federal standards were evaluated. It had been alleged that: (1) the validity of the nursing home inspection process was compromised because facilities received advance notice of inspections; (2) inspection reports were being weakened by supervisors; (3) the state was not investigating patient complaints in a timely manner; (4) the state was not sharing information on patient complaints with the federal government; (5) the state was lax in instituting enforcement action against facilities with deficiencies; and (6) inspection and enforcement actions were biased in favor of certain facilities. The GAO investigation did not substantiate the allegations. Problems identified in the investigation were discussed with the state and actions have been taken to correct the problems. (NB)

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United States General Accounting Office

GAO

Report to the Honorable Bill Green
House of Representatives

November 1986

HEALTH FACILITIES

New York State's Oversight of Nursing Homes and Hospitals

CG 020389

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United States
General Accounting Office

New York Regional Office

Room 4112, 26 Federal Plaza
New York, NY 10278

B-225038

November 28, 1986

The Honorable Bill Green
House of Representatives

Dear Mr. Green:

Your June 7, 1985, letter expressed concern about the adequacy of nursing home and hospital inspections made by the New York State Department of Health—particularly in the New York City area—to assure that these facilities meet the conditions for participation in the Medicare and Medicaid programs. These inspections are made for the federal government under an agreement between the state and the Department of Health and Human Services (HHS). The agreement is administered by HHS's Health Care Financing Administration (HCFA). Your letter cited certain allegations made to you about defects in the inspection process that could lead to the certification of substandard facilities for participation in the programs and, thereby, result in beneficiaries receiving substandard care.

Overall, our review did not substantiate the allegations. We did identify some problems with the state's processes for inspecting facilities and investigating complaints about them. Since we discussed these problems with the state, it has taken or is taking action to correct them. Therefore, we are not making recommendations in this report.

A summary of the allegations and our findings follows:

- It was alleged that the validity of the nursing home inspection process was compromised because facilities received advance notice of inspections and could prepare for them. We found no evidence that nursing homes were receiving advance notice. However, because of the periodic nature of the inspections, facilities could anticipate, within a few weeks, when the state would arrive. The state had requested HCFA's permission to inspect some nursing homes on a random basis, which would lessen the facilities' ability to anticipate when they will be inspected. HCFA approved this proposal as a demonstration project to begin in August 1987. (See p. 10.)
- Inspection reports were allegedly being weakened by supervisors who reviewed and revised them so that substandard facilities would appear to meet the conditions of participation. Although some changes were made to inspection reports based on supervisory review, they were

mainly editorial and, for the reports we examined, did not suppress findings of deficiencies. (See p. 11.)

- The state was alleged not to be investigating patient complaints in a timely manner. Investigations of patient complaints were generally begun within the time periods established by state policy. The time to complete the investigations had been quite lengthy, but recent state actions have decreased investigation times. For example, in the New York City area, the time required to investigate valid nursing home patient abuse complaints decreased from 290 to 170 days from January 1984 to October 1985. (See p. 13.)
- It was alleged that the state was not sharing information on patient complaints with the federal government. Although such sharing is required under the state's agreement with HHS, the state had not routinely done so. In June 1985, the state began sharing information on hospital-related patient complaints, and HCFA officials advised us that they are considering obtaining additional information under the sharing arrangement with the state. (See p. 16.)
- The state was allegedly lax in instituting enforcement action against facilities with deficiencies identified through the inspection process. The state increased emphasis on enforcement actions against nursing homes in 1983 and against hospitals in 1985. However, action against hospitals had not been consistently taken, and negligent physicians were not being referred for investigation as required by state policy. The state agreed with our findings on consistency and referral of physicians and has acted to assure more consistent application of its policies. (See p. 17.)
- According to the allegations, inspections and enforcement actions were biased in favor of certain facilities, resulting in the continued participation of substandard facilities in Medicare and Medicaid. We found no evidence of bias; however, we noted that the state lacked adequate internal controls to prevent conflicts of interest. During our fieldwork, the state established an internal review activity to check compliance with law and policies by its hospital surveillance units. A similar internal review activity was already in place for its nursing home units. In addition, the state is developing a more complete disclosure requirement for its employees. (See p. 21.)

We noted one other problem not directly related to the allegations. Specifically, the staff responsible for inspections and the staff responsible for investigating complaints were not regularly exchanging information about the results of their work. Information on inspection results could be useful in investigating complaints, and vice versa. In fact, HCFA and state policy both require the exchange of information as a means of assuring the quality of both the complaint investigation and facility

inspection processes. During our fieldwork, the state acted to improve the exchange of information, and the state also advised us that additional measures have been or will be undertaken. (See p. 22.)

These issues are discussed in more detail in appendix I.

Objective, Scope, and Methodology

Our objective was to evaluate the validity of allegations about deficiencies in the New York State Department of Health's nursing home and hospital inspection processes for certification for participation in the Medicare and Medicaid programs. The allegations we evaluated were those included in your request for our review, as supplemented during meetings with you and your staff and with the persons making the allegations.

To address the allegations, we evaluated HCFA and state policies, procedures, and practices for investigating complaints, performing inspections, and determining nursing home and hospital compliance with federal standards. In addition to reviewing federally authorized enforcement actions against deficient hospitals and nursing homes, we examined the state's use of additional, state-authorized actions.

To address issues regarding facility inspections, we (1) interviewed those making the allegations and examined the evidence they provided, (2) examined inspection reports of eight nursing homes and six hospitals, (3) interviewed inspection staff, and (4) interviewed individuals and examined information available outside the state agency.

Regarding patient complaint investigation issues, we examined (1) available state-maintained data on investigation timeliness, (2) samples of investigated nursing home and hospital complaints to determine case-processing time, and (3) state sharing of complaint information with HCFA.

We used information we developed while looking into inspection and complaint issues to evaluate the state's enforcement activities. In addition, we obtained historical information on enforcement actions against nursing homes and hospitals.

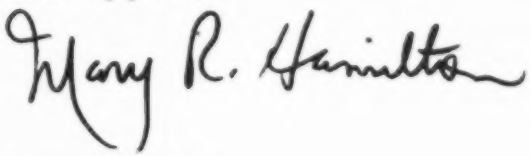
Our fieldwork was done from June 1985 through June 1986 and generally covered the state's inspection, complaint investigation, and enforcement processes for 1983 through 1985. As you requested, we focused on the State Department of Health's New York City Area Office. There are

six area offices statewide; New York City area facilities account for about a third of the state's skilled nursing home population and almost half of its acute care hospital population. During our review, we visited the Albany and Syracuse area offices to meet with staff and obtain a perspective on office operations. We did not evaluate certain other allegations brought to our attention because the New York State Attorney General was investigating these and other related matters.

As agreed with you, we discussed this report with state and HCFA officials and considered their comments in completing it. Our work was performed in accordance with generally accepted government auditing standards.

As requested by your office, unless you publicly announce its contents earlier, we will make no further distribution of this report for 3 days. At that time we will send copies to the Secretary of HHS, the Commissioner of the New York State Department of Health, appropriate congressional committees, and other interested parties.

Sincerely yours,



Mary R. Hamilton
Regional Manager

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Abbreviations

DOH	New York State Department of Health
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services

New York State's Oversight of Nursing Homes and Hospitals

Background

The Medicare and Medicaid programs, authorized by titles XVIII and XIX of the Social Security Act, are administered by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS). Medicare assists almost all persons 65 and over and certain disabled persons in paying for their health care needs. Medicaid pays for a wide variety of health care services for recipients of cash assistance and for other low-income persons unable to pay for needed health services.

The Social Security Act and implementing regulations establish requirements that hospitals, nursing homes, and other health care providers and suppliers must meet to participate in the Medicare and Medicaid programs. The act directs HHS to use state health agencies or other appropriate agencies to determine whether health care institutions meet established standards. HHS enters into an agreement with the designated state agency to inspect Medicare and Medicaid providers and suppliers and to determine if they meet the standards.

In New York, the State Department of Health (DOH) is the designated state agency. Under its agreement with HHS, DOH annually inspects all nursing homes to determine and recommend to HCFA whether they are in compliance with federal standards, known as the "conditions of participation," and whether to certify them for participation in Medicare and Medicaid. If HCFA concurs with DOH's recommendation, HCFA will enter into a provider agreement with the nursing home for Medicare, and the state will enter into such an agreement for Medicaid. Both provider agreements are usually for 1 year. In addition, DOH investigates complaints against nursing homes. As of September 1985, there were 564 skilled nursing facilities in New York, including 151 in the New York City area.

As authorized by the Social Security Act, hospitals accredited by the Joint Commission on the Accreditation of Hospitals are deemed to meet the conditions of participation. The Joint Commission is a private, nonprofit organization that conducts voluntary accreditation and education programs for health care facilities, including hospitals. All but 7 of New York's 281 Medicare-participating hospitals are accredited by the Joint Commission, which usually accredits hospitals for 3 years. DOH's agreement with HHS requires DOH to conduct validation surveys of a sample of Joint Commission-accredited hospitals to assess the adequacy of the Commission's survey. The state is also required to investigate complaints made against hospitals. There are 79 Medicare-participating hospitals in New York City.

Under federal law, nursing homes and hospitals not substantially complying with the conditions of participation can be terminated from program participation by HCFA and denied Medicare and Medicaid reimbursement. In lieu of termination, sections 1866 and 1902 of the Social Security Act authorize a ban on payment for new Medicare and Medicaid admissions to nursing homes that fail to correct deficiencies not severe enough to close the home. In addition to federal sanctions, the New York State Health Code authorizes fines and other penalties against facilities and their staff for code violations.

For nursing home and hospital inspections and investigations, DOH is organized into a central office in Albany and six area offices throughout the state. The New York City Area Office covers more facilities than any other office.

In the New York City Area Office, the Long Term Care Unit is responsible for conducting inspections of nursing homes, and the Hospital Program Unit is responsible for validation surveys of hospitals. A third unit—the Patient Care Investigation Unit—was responsible for investigating complaints against both nursing homes and hospitals. However, in April 1985, responsibility for investigating hospital complaints was transferred to the Hospital Program Unit.

The Nursing Home Inspection Process

The nursing home inspection process generally proceeds as follows: About 150 days before a nursing home's 1-year certification expires, it is sent a questionnaire designed to gather data necessary for the upcoming inspection. A team from the area office's Long Term Care Unit is assigned to conduct the inspection. In preparing for the inspection, the team is supposed to review the data obtained through the questionnaire, previous reports of inspections, and information on complaints against the facility. The team then visits the facility for 1 day or more and inspects it for compliance with the federal conditions of participation and state requirements.

After the visit, each team member writes up the section of the inspection report for which he or she is responsible. The team leader consolidates all sections of the report, which is then reviewed by a team coordinator and the unit's director.

If the inspection identifies deficiencies, the nursing home is given an opportunity to submit a plan of correction, which is reviewed by the

team for adequacy. Visits to the facility may be made to check on its implementation.

The area office inspection report is forwarded to the Bureau of Long Term Care Services in the DOH central office for review of, and concurrence with, the compliance determinations and for appropriate enforcement action, if any. DOH then recommends to HCFA whether the facility should be certified for program participation and forwards the inspection report to HCFA for review. HCFA then decides whether the facility can participate in Medicare and Medicaid.

The Hospital Inspection Process

As stated on page 8, most hospitals in New York State are accredited by the Joint Commission. They are not subject to annual state inspections as nursing homes are. Besides validation surveys performed at HCFA's direction, DOH inspects hospitals when there are indications that they are not meeting state health codes. The inspection and reporting processes are similar to those for nursing homes.

The Complaint Investigation Process

The area office receives complaints from patients and others about nursing homes and hospitals. After a complaint is investigated, the person doing the investigation prepares a report, which is reviewed by supervisory personnel in the area office. Nursing home patient abuse reports are further reviewed by the DOH central office. Under the agreement with HHS, DOH is supposed to give HCFA information on complaints against facilities.

Under state law, hospitals are supposed to report any "incidents"—which are defined as adverse consequences for patients that are not part of the normal progress of their illness or injury. A similar process to that used for complaints is used by the state to investigate hospital-reported incidents.

Do Nursing Homes Have Advance Notice of Inspections?

It was alleged that the inspection process, particularly for nursing homes, was compromised because providers received advance notice of inspections, which is contrary to federal and state policy. We found no evidence of this occurring, but because the inspection process is cyclical, nursing home operators can anticipate—to within a few weeks—when an inspection will occur.

Federal and state policies require that nursing home inspections be unannounced. Although several of those who made allegations told us that nursing homes seemed prepared for the inspections, only one person alleged that DOH told facilities when an inspection would begin. Neither this person nor other complainants had any direct evidence to support this claim.

Federal regulations require that Medicare/Medicaid provider agreements be issued for a 1-year period. About 150 days before the provider agreement expires, DOH requests a facility to provide various facility and patient data. This action alerts a facility of an impending inspection, which begins 90-120 days before the provider agreement expires. For example, for the eight New York City Area Office nursing home inspection reports we examined in detail, the 1983, 1984, and 1985 inspections were conducted within a month of the previous year's inspection.

Inspection staff we spoke to in the New York City, Albany, and Syracuse Area Offices agreed that the inspection process was very predictable, allowing facilities to prepare for an inspection. However, many of the inspectors said that although facilities could prepare for inspections by paying closer attention to patient and building cleanliness, systemic deficiencies, such as a pattern of understaffing, would still be detected. Most inspectors believed that inspecting some facilities on a random basis would provide better assurance that facilities could not prepare for inspections by anticipating inspection dates. Recognizing the problem of inspections being predictable, DOH proposed to HCFA that a 10-percent sample of "off-cycle" inspections be performed annually. HCFA has approved this proposal as a demonstration project to begin in August 1987.

Were Findings in Inspection Reports Suppressed by Supervisors?

There were allegations that nursing home inspection reports were being weakened, altered, or censored to allow facilities that performed poorly to meet the conditions of participation. We found that supervisory reviews resulted in changes to inspection reports, but the changes we reviewed did not suppress inspection findings.

As stated, multidisciplinary teams from the Long Term Care Unit in the New York City Area Office conduct nursing home inspections. After an inspection is completed, each inspection team member prepares a written report of his or her inspection segment; the inspection team leader then consolidates those segments into an overall report. Later, the team coordinator, the Long Term Care Unit director within the New

York City Area Office, and the Bureau of Long Term Care Service Quality Assurance staff in DOH's central office review the report. After a 1984 HCFA evaluation raised some criticisms about the quality of inspection-report documentation and report-processing timeliness, these supervisory reviews became more intense. Steps were taken to strengthen the review process to assure better documentation to support DOH and HCFA enforcement efforts and to improve report-processing timeliness.

We reviewed seven nursing home inspection reports to which significant changes were alleged to have been made. We analyzed complainant-provided documents, as well as case records, and compared this information to regulations and HCFA's guidelines for determining whether a facility meets the federal conditions of participation. We also asked the HCFA staff responsible for oversight of the nursing home inspection process whether the changes made to reports were justified. Based on the information we obtained and analyzed, the changes were justified. Most of these changes involved citing a deficiency under a more appropriate standard; none had the effect of suppressing a deficiency.

We also analyzed eight other 1985 nursing home inspection-report case files[1] and discussed the issue of altered inspection reports with 11 staff members involved with these inspections. None of these reports had been changed, except for editorial changes that helped clarify cited deficiencies.

Besides nursing home inspection staff, we spoke to New York City Area Office staff who investigated nursing home complaints. They said that changes to their investigation reports were usually editorial. We also spoke to New York City Area Office staff responsible for hospital inspections and complaint investigations. Most of these staff said they had not experienced supervisory changes to their reports that deleted deficiency findings. Some felt that detail was eliminated from their investigation reports, but in the seven cases they supplied that we examined, the hospital was nonetheless cited for the identified deficiency.

[1]The case files were judgmentally selected to cover nursing homes reviewed by each of the four teams and a mixture of nonprofit and for-profit homes as well as homes with, and some without, identified deficiencies.

We also discussed the matter of altered reports with Albany and Syracuse Area Office staff responsible for nursing home and hospital inspections and complaint investigations. They said that changes to their reports were largely editorial.

Were Patient Complaint Investigations Timely?

One of the allegations was that patient care complaints were not handled in a timely manner. We found the time required to complete investigations had been quite long. However, the time needed to complete nursing home and hospital complaint investigations has declined since 1984, and further reductions may be forthcoming.

Under its agreement with HHS, DOH is to investigate complaints made by, or on behalf of, patients in nursing homes and hospitals. It also investigates incidents involving adverse patient outcomes reported by nursing homes and hospitals. Until October 1985 there were three categories of complaints:

- Nursing home patient abuse complaints, which may be reported by patients or their friends or relatives or by nursing home employees under a state law requiring reports of all incidents involving possible patient abuse, mistreatment, and neglect.
- Other nursing home complaints, which do not involve allegations of specific patient mistreatment (for example, poor food or inadequate heat).
- Hospital complaints made by individuals, alleging poor patient care and other problems with hospitals.

In October 1985 a fourth category—hospital-reported incidents—was added. The category mainly involves incidents of patient deaths or impairment not related to the natural course of an illness or injury. Hospitals must report such incidents to DOH under state law. Because this law was implemented recently, we did not analyze how quickly hospital incidents were investigated.

Table I.1 shows the complaints reported both statewide and in the New York City Area Office in 1985.

Table I.1: Complaints Received Statewide and in the New York City Area (1985)

Category of complaint	Statewide	New York City Area Office
Nursing home patient abuse complaints	1,806	1,038
Other nursing home complaints	1,553	789
Hospital complaints	1,400	807
Hospital-reported incidents	645[a]	262[a]
Total	**5,404**	**2,896[b]**

[a]October-December 1985.

[b]Represented 54 percent of complaints reported statewide.

Complaint Investigations Are Being Done More Quickly

HCFA requires that DOH promptly investigate allegations of health and safety hazards, inadequate patient care, or noncompliance with the conditions of participation or other program requirements. The time required to complete nursing home and hospital complaint investigations in the New York City Area Office has decreased, and investigations are generally initiated within state time frames. This decrease, especially in regard to hospital complaints, followed an April 1985 reorganization of the complaint investigation responsibilities. At that time, responsibility for investigating complaints involving hospitals was transferred to a subunit of the validation surveys unit for hospitals. Also, the number of nonsupervisory staff assigned to the investigative function increased from 15 to 26. Further improvements in timeliness may be forthcoming, particularly concerning the nursing home complaint caseload, once the full effects of the reorganization are felt in terms of reduced case backlogs.

DOH officials believe that management of nursing home patient abuse complaints should also benefit from the statewide introduction of the Patient Abuse Reporting System—an automated case management system for nursing home abuse complaints. This system will enable area and central office management to monitor complaint case progress. DOH plans to give area offices access to the system in 1987.

Nursing Home Patient Abuse Complaints

State law requires DOH to begin investigating nursing home patient abuse complaints within 48 hours of receiving them. In life-threatening situations, state procedures require that the state seek immediate corrective action. There are no guidelines on how long it should take to investigate, review, and adjudicate cases. These complaints are first investigated by

an area office and then referred to the central office in Albany for a final determination of their validity.

Based on a random sample of 25 New York City Area Office cases for which determinations were made in August 1985, we found that nursing home patient abuse investigations began at the nursing home within 48 hours of receipt, as required by state law. None of the 25 cases involved life-threatening situations. Regarding complaint investigation time, we observed an overall downward trend during the 22-month period from January 1984 through October 1985. For cases in the New York City Area Office where DOH determined that complaints were justified, the data showed a marked decrease in investigation time—from about 290 days in January 1984 to about 170 days by October 1985. Case review times in the central office also decreased from an average of about 250 days in January 1984 to about 130 days by October 1985.

Complaints that the central office sustains are subject to further review by DOH's Division of Legal Affairs because the accused individual can request a hearing. There was no statewide data on how much additional time that division took to adjudicate sustained complaints. We determined the total elapsed time for all 24 cases originating in the New York City Area Office that the Division of Legal Affairs closed in August 1985. Investigating and adjudicating these 24 cases took an average of 1,065 days.

According to staff at the New York City Area Office and at the central office in Albany, lengthy processing times sometimes resulted in sustained complaints being dismissed because abused nursing home patients were unable to testify—some had died and others could not recall the cited events. Of the 25 New York City Area Office complaints we sampled that were processed by the central office in August 1985, 9 were sustained. However, one of these could not be further processed because the elderly patient—the only witness to the abuse—died before a determination was rendered. Central office staff said they now give priority to cases in which the abused patient is the only witness.

Other Nursing Home Complaints

No statewide information was available on how long "other" nursing home complaint investigations take. We analyzed all 27 complaints that did not allege patient abuse that the New York City Area Office closed in August 1985. For 17 of these 27 nonabuse complaints, the cases were closed within 2 months of opening; 2 complaints took more than 6

months. Investigative staff explained that these cases often required less effort because they involved less complex issues.

Hospital Complaints

There are no specific federal time standards for starting and finishing hospital complaint investigations, but DOH requires that investigations begin within 14 days and be completed within 60. There were no data on how long it took, either statewide or in area offices, to process hospital complaints. We developed information on all closed complaints (except for billing matters) made against 24 randomly selected New York City area hospitals from 1983 to 1985, for periods before and after the April 1985 reorganization of the hospital complaint investigation function. We found that before the reorganization, an average investigation began 51 days and was completed 198 days after a complaint was received. Since the reorganization, these processing times have decreased to 9 and 53 days, respectively.

Was the State Withholding Complaint Information From HCFA?

There were allegations that DOH was not sharing patient care complaint information with HCFA. HCFA's 1983 and 1984 evaluation reports of DOH's inspection program criticized DOH for not sharing complaints, especially hospital complaints, as required under the HHS-DOH agreement. HCFA needs this information to monitor the quality of care of providers. Although DOH began to share hospital complaint information in June 1985, it has not routinely shared with HCFA information on hospital-reported incidents and on certain nursing home complaints. HCFA is considering an arrangement to obtain additional complaint information from DOH.

DOH's agreement with HHS requires it to forward to HCFA all allegations of poor quality care or other indications of noncompliance with standards in hospitals accredited by the Joint Commission. Because most hospitals in New York are so accredited and are normally inspected only every 3 years, complaints are an important source of information between inspections about the quality of care in hospitals participating in Medicare.

After being criticized for not sharing complaint information, DOH, in June 1985, began to send HCFA information on hospital complaints made by or on behalf of patients. It also started to send HCFA investigation results when a statement of deficiency (a formal finding that an institution has violated federal or state standards) was issued. DOH also offered to share Joint Commission accreditation reports.

However, DOH gives HCFA only limited information on hospital-reported incidents. State law requires hospitals to investigate incidents and to make a report of the investigations, including corrective actions, to DOH. DOH has not passed on the hospitals' investigation results because HCFA has not asked for them. DOH gives HCFA statements of deficiencies resulting from its investigation of hospital-reported incidents, but it investigates only a small proportion of them. Although the law does not require DOH to investigate incidents, it will generally investigate incidents of patient deaths and other incidents believed to be significant. Statewide, DOH investigated 14 percent of the incidents reported and closed from October 1985 through March 1986.

HCFA regional staff and DOH officials told us they will work together to develop a more complete sharing arrangement for hospital-reported incidents.

HCFA had also criticized DOH for not sharing nursing home complaints. Because the confidentiality provision of the state's nursing home patient abuse complaint law prevents disclosure, except for substantiated complaints, DOH will give HCFA information only on substantiated complaints. Although this is contrary to the HHS-DOH agreement, it is HCFA national policy not to require specific complaint reporting if this conflicts with state law. However, HCFA regional staff told us they plan to seek selective access to complaint information when evaluating how well DOH carries out its nursing home complaint investigation and inspection responsibilities. DOH officials told us such access will be permitted.

Was the State Lax in Taking Enforcement Action Against Deficient Facilities?

There were allegations that DOH was lax in taking enforcement action against poorly performing nursing homes and hospitals. We found that DOH increased enforcement actions against nursing homes in 1983 and that it has also taken action against negligent nursing home staff. Enforcement actions against hospitals increased in 1985. However, these actions have sometimes been inconsistent. Furthermore, the Bureau of Hospital Services, which supervises area office hospital program units, did not, as required by state policy, routinely refer negligent physicians to the physician disciplinary authority for investigation and possible action. DOH is working to correct these problems.

Enforcement Actions Are Taken Against Nursing Homes and Their Staffs

Enforcement action is taken against nursing homes and their negligent staffs when deficiencies are identified. However, because the combined inspection and enforcement processes are time consuming, the overall process may give the appearance of inaction.

The Social Security Act authorizes a ban on admissions of new Medicare/Medicaid patients or termination of provider agreements with nursing homes (1) not substantially complying with federal conditions of participation or (2) having repeat deficiencies. DOH's state-authorized enforcement actions include fining a facility, revoking an operator's license, closing a facility, or replacing an operator with a court-appointed receiver.

From 1982 through 1985, DOH initiated 80 enforcement actions against 58 nursing homes and collected about $400,000 in fines from 47 homes. All but two of the enforcement actions occurred in 1983, 1984, and 1985. Of the 80 actions, 41 were taken against facilities for which the New York City Area Office is responsible. Facilities in the New York City area account for just over 25 percent of the nursing homes statewide. In addition, half of the pending enforcement actions are also against facilities for which the New York City Area Office is responsible.

Included in the 80 enforcement actions were admission bans at 18 nursing homes, including 14 in the New York City area. In 1985, DOH recommended bans at 38 nursing homes because of noncompliance with the conditions of participation. All but seven of these homes corrected their deficiencies and had the sanctioning recommendation rescinded.

Besides assessing penalties against nursing homes, DOH fines nursing home staff who abuse or neglect a patient, based on a state law implemented in 1977. In 1985, DOH's Division of Legal Affairs closed 343 cases, resulting in fines totaling $31,650 in 221 cases. In addition, seven cases sustained against physicians were referred to the Office of Professional Medical Conduct for further investigation and possible disciplinary action.

We analyzed allegations concerning DOH's failure to take enforcement action against four nursing homes. Our analyses indicated that DOH was taking action in each case.

Our analysis of eight additional nursing home inspection histories indicated that DOH had initiated enforcement against the four facilities with

identified deficiencies. Partly due to legal process requirements, a year or more may elapse between an inspection identifying a deficiency and the enforcement action against the offending institution. Although each of the four inspections was conducted in early 1985, enforcement action had not been completed by October 1986. Further, enforcement action stemming from a May 1984 inspection of one of these facilities was not completed until October 1986.

Hospital Enforcement Actions Have Increased but Have Been Inconsistent

Enforcement statistics show that until 1985, enforcement actions against hospitals—statewide and in New York City—were infrequent. Data show that enforcement activity increased in 1985. However, we noted situations with similar characteristics that were not treated the same by the New York City Area Office.

Enforcement actions against hospitals with serious deficiencies consist of decertification from Medicare and Medicaid program participation, fines, or the suspension or revocation of their operating certificates.

There were almost as many enforcement actions in 1985 (19) as there were in the previous 3 years (25). Twice as many enforcement actions (13) were taken against New York City area hospitals in 1985 as were taken in the rest of the state (6). In addition, 60 enforcement actions were pending in March 1986, including 27 against New York City area hospitals.

Enforcement actions taken before 1985 usually related to complaints or other incidents that received media publicity. Since 1985, however, enforcement actions have more frequently been based on a hospital's total performance, rather than on just complaints or incidents. Two of the six hospitals' surveillance histories we reviewed in detail are New York City municipal hospitals. Although both hospitals' histories, including complaints, showed continued deficiencies, no prior enforcement action had been taken. In December 1985, the New York City Area Office recommended that such action be taken. Action against one hospital was completed in June 1986, and action against the other was still pending as of October 1986.

The New York City Area Office has not been consistent in recommending matters for enforcement. Some complaints and other incidents at the six hospitals we reviewed in detail were not considered for enforcement, even though they were similar to matters for which enforcement action had been taken or was being considered. For

example, a hospitalized patient died in November 1985 as a result of a mistaken injection of potassium chloride. As of October 1986 this incident was pending with DOH's counsel for enforcement action. A patient at another hospital also received a mistaken injection of potassium chloride. That patient suffered cardiac arrest, but was revived. Although the incidents were similar and remedial action taken for both, the New York City Area Office did not refer the latter incident for enforcement. We found a similar lack of uniformity in referrals in several obstetric cases.

In commenting on these observations, DOH indicated that the two incidents involving mistaken potassium chloride injections were dissimilar enough to influence enforcement consideration. According to DOH, there were differences in patient outcomes, and in the incident where enforcement action was initiated, the hospital failed to take prompt remedial action. Regarding the latter comment, we noted that both hospitals initiated remedial action before DOH completed its on-site investigations. The investigation at the hospital against which enforcement action was taken was completed 6 days after the incident occurred. The investigation at the hospital against which no enforcement action was taken was completed within 18 days.

While DOH officials did not fully agree with our observations about the potassium chloride incidents discussed earlier, they did say that inconsistent enforcement consideration was a statewide problem. They said that enforcement policy would be applied more consistently in the future. The implementation of internal audits in January 1986 (see p. 22) and the development of the automated hospital profile system[2] should, according to these officials, identify situations that are not treated equally. In addition, DOH gave us a schedule of training on enforcement criteria and procedures that they said was conducted in June and August 1986.

Physicians Are Not Always Referred for Disciplinary Action

Because enforcement actions resulting from inspections or complaint and incident investigations are taken against the involved hospitals, physicians directly involved with the complaints or incidents must be referred to the Office of Professional Medical Conduct to complete the surveillance loop. Contrary to DOH policy, the Bureau of Hospital Services, which supervises area office hospital program units, was not routinely making such referrals.

[2]This system is being designed to incorporate information for each hospital on state survey findings, complaint investigations, and hospital-reported incidents.

The Office of Professional Medical Conduct within DOH is responsible for investigating complaints of medical misconduct and initiating disciplinary action against physicians and their assistants. Under New York State Education Law, medical misconduct includes practicing the profession fraudulently, beyond the scope of practice authorized, with gross incompetence or with gross negligence on a particular occasion, or with negligence or incompetence on more than one occasion. In 1985, the Bureau of Hospital Services referred 58 physicians to the Office of Professional Medical Conduct. Hospitals, required by state law to make referrals, reported 116 physicians to the office.

We reviewed nine enforcement cases against New York City Area Office hospitals active as of March 1986, involving 16 physicians, to determine if the Bureau of Hospital Services had referred the involved physicians to the Office of Professional Medical Conduct. According to that office, in two of the hospital cases the bureau had not referred the four physicians involved. In only one of the nine cases did a hospital report a physician to the office. The bureau had also reported the physician involved in this matter.

We also examined six other complaint and incident cases with serious patient outcomes that the New York City Area Office had received but had not referred for enforcement. We learned that the Bureau of Hospital Services also had not made any referrals related to these cases and that in two cases the hospitals involved had referred the physicians.

DOH officials advised us that, as a result of our observations, the Bureau of Hospital Services is referring to the Office of Professional Medical Conduct all physicians involved in an incident, complaint, or enforcement action. In addition, inspectors will be directed to pay closer attention to hospital practices to comply with state requirements to report medical misconduct.

Were Inspections Biased in Favor of Some Facilities?

The final allegation was that inspections and enforcement actions were biased to allow poorly performing nursing homes and hospitals to participate in the Medicare and Medicaid programs. We did not detect evidence of bias in the nursing home and hospital inspections and complaints we examined; however, as discussed earlier, we did note inconsistencies in hospital enforcement actions. We found that DOH had neither a clear policy regarding potential conflicts of interest nor a mechanism within the Bureau of Hospital Services to detect bias that could result from conflicts. Adequate internal controls require that

employees disclose affiliations they or their immediate family members may have with nursing homes and hospitals that might represent a conflict of interest.

DOH officials told us they are developing a more complete policy regarding the disclosure of employment and assets of DOH employees, their spouses, and unemancipated minor children. Further, an internal audit function implemented in January 1986 by the Bureau of Hospital Services should help detect inconsistent application of laws and policies, including those for conflict of interest, in the oversight of hospitals. There is a similar internal review function within the Bureau of Long Term Care Services responsible for nursing home surveillance.

Complaint and Inspection Activities Had Not Been Adequately Coordinated

In addition to looking into the allegations, we noted one other problem—information was not routinely exchanged between the complaint investigation staff and the facility inspection staff. DOH and HCFA require that complaint investigation results be provided for inspection purposes and that a facility's inspection history be reviewed before investigating complaints. Such coordination is intended to assist each function by making it aware of problems the other function has identified in the past.

Nursing Home Inspections Are Poorly Coordinated With Complaint Investigations

The New York City Area Office's Patient Care Investigation and Long Term Care staffs do not routinely share information. Moreover, complaint information that was shared had little influence on inspection activities because it was often not received on time or in a useful form, and complaint investigators did not receive inspection histories when investigating complaints.

The Patient Care Investigation Unit accumulates complaint information for each nursing home. Before each annual nursing home inspection, staff manually compile a complaint summary for the Long Term Care Unit. Most inspection staff we spoke to considered the information on complaint investigations they received to be of little value for inspection planning because

- the information was often not received in time,
- the description of complaint investigation results was too general to identify potential systemic problems, and
- most complaint investigation descriptions did not include investigation results.

Moreover, the Long Term Care Unit did not update patient complaint information before making follow-up visits to facilities with identified deficiencies, nor did it use complaint information in deciding whether corrective action plans prepared by the facility were adequate to remedy the deficiencies.

On the other hand, the Long Term Care Unit did not provide inspection results to the Patient Care Investigation Unit, nor did the latter unit seek such information. Consequently, complaint investigators were generally not familiar with nursing home inspection histories.

To overcome the organizational and other barriers to effective information exchange, the New York City Area Office administrator, in the fall of 1985, directed that "bridge meetings" be conducted by the two units. Two such meetings were held in October; however, they did not resume until February 1986. According to inspection staff we spoke to, the earlier meetings did not result in more or better information being provided to them. Thus, it does not appear that the action taken was having the intended effect. Staff from both units indicated that providing complaint information as received by the Patient Care Investigation Unit—such as sending the Long Term Care staff a copy of the standard complaint form—would enable complaints to have a greater influence on the inspection process. The complaint form includes a description of the complaint, the name of the facility where it occurred, and other pertinent information.

In responding to these observations, DOH officials told us there have been regular twice-monthly bridge meetings since February 1986. They also said they have tried to improve the format of information sharing.

Hospital Inspections Are Poorly Coordinated With Complaint Investigations

Despite the April 1985 transfer of responsibilities for conducting hospital complaint investigations to the hospital program unit, hospital inspection activities remain poorly coordinated with hospital complaint investigations. The three inspection team directors told us that they were still not being routinely apprised of either all incoming complaints or all investigation outcomes.

The complaint staff (1) prepares and forwards to hospitals statements of deficiencies and (2) reviews and decides whether to accept plans of corrections submitted by hospitals. Although inspection staff are responsible for following up on plans of correction, accepted plans were being filed in the complaint files without review by inspection staff.

Thus, unless they examined the complaint files to prepare for an inspection, inspection staff were not aware of plans of correction—plans for which they were responsible for assuring facility compliance.

As a result of our observations, the New York City Area Office administrator said that action has been or will be taken to assure more routine and timely sharing of information. For example, inspection team directors must review statements of deficiencies and plans of correction resulting from complaint investigations. Inspection staff were directed to review all complaint and inspection files before an inspection. In addition, a monthly report of hospital-reported incidents has been developed for distribution to the inspection and complaint team directors. A similar monthly report is planned for complaints, according to the officials. Further, they believe that the hospital profile system planned for early 1987 will facilitate coordination.